

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **10180**  
Registrar's No. **2053**

**FILED MAR 24 1952**

**318**

**1003**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>2053</b>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS Mo</b>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS 2029</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. ANTHONY'S Hospital - 2</b>				d. STREET ADDRESS (If rural, give location) <b>4664 DAHLIA</b>			
3. NAME OF DECEASED (Type or Print): a. (First) <b>MAYME</b>		b. (Middle) <b>-</b>		c. (Last) <b>KALINA</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>MAR. 2 1952</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>DEC. 8 1890</b>	9. AGE (In years last birthday) <b>61</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 6 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>ST. LOUIS MO U</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>JOHN BORICK</b>		13b. MOTHER'S MAIDEN NAME <b>CHRISTINE SCHENK</b>		14. NAME OF HUSBAND OR WIFE <b>LOUIS KALINA</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT'S SIGNATURE OR NAME <b>LOUIS KALINA</b> ADDRESS <b>4664 DAHLIA</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>		<p align="center"><b>MEDICAL CERTIFICATION</b></p> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Congestive Heart Failure</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Bronchial asthma</b> DUE TO (c) <b>Hypostatic Pneumonia</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>  <b>2 weeks</b>  <b>10 days</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>241X</b>			
22. I hereby certify that I attended the deceased from <b>2/11, 1952</b> , to <b>3/2, 1952</b> , that I last saw the deceased alive on <b>3/2, 1952</b> , and that death occurred at <b>4:25 p.m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>Walter J. Gunn</b> (Degree or title) <b>0</b>				23b. ADDRESS <b>4617 Dahlia</b>		23c. DATE SIGNED <b>3/3/52</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>MAR. 5 1952</b>	24c. NAME OF CEMETERY OR CREMATORY <b>S.S. PETER + PAUL</b>		24d. LOCATION (City, town, or county) (State) <b>ST. LOUIS MO</b>		
DATE REC'D BY LOCAL <b>MAR 4 1952</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas Rute</b> ADDRESS <b>2906 Gravois</b>			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed \_\_\_\_\_

*Leo J. Budde*

Signed.....  
Student Embalmer

Licensed Embalmer No. 3989

P. O. Address St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.